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CHAPTER SEVEN

Community-Driven Asset Identification and Issue Selection

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When residents of Tillery, North Carolina, began to suspect that the chronic sore throats, itchy eyes, and other health problems besetting their community were tied to the open lagoons and other practices of the hog production industry, they began their own "barefoot epidemiology" to document what was taking place. Impressed by their efforts, a journalist connected their organization, Concerned Citizens of Tillery (CCT), with researchers at the University of North Carolina's School of Public Health, and an exemplary CBPR project got under way (Wing, Grant, Green, & Stewart, 1996).

The Tillery case study, which is presented in Chapter Eleven, is in many ways an ideal case. The issue around which CBPR took place came directly from the community, which subsequently began its own study and then partnered with both a university and the local health department to conduct the more detailed research needed and advocate for change. Yet in many cases, it is outside researchers or practitioners, rather than communities themselves, who wish to embark on a CBPR project. As Randy Stoecker suggests in Chapter Five, in such cases, the outsider frequently plays the role of initiator, approaching community organizations about the possibility of a collaboration and setting the process in motion. In other instances, typified by the Healthy Communities approach, a neighborhood or community may decide that it wishes to create a better and healthier environment for its citizens and embark on a process of identifying its assets and studying and addressing the things it hopes to change.

In this chapter, we examine the processes of community-driven issue selection, giving particular attention to the roles that outside researchers or practitioners may play in facilitating this process. In keeping with the emphasis in CBPR on recognizing and building on community capacity, however, the chapter is equally concerned with the often similar processes through which communities may be helped to identify and build on their resources. We begin with a brief review of the core principles guiding a participatory and strengths-based approach to community asset identification and issue selection. Next we present a variety of methods and approaches for assisting communities in identifying their assets and resources as well as their concerns and issues. We then review some key criteria, adapted from the field of community organizing, that may usefully guide community issue selection in CBPR. Finally, we highlight the challenge that arises when categorical funding and other factors constrain issue selection in a participatory research effort. Using as an example the federal Healthy Start program to reduce infant mortality, we illustrate how even within such constraints, a commitment to community participation and empowerment can lead to high-level community involvement in deciding on the issues on which collective research and action will take place.

CORE PRINCIPLES AND CONSIDERATIONS

The approaches to community identification of assets and issues described in this chapter are grounded in a conceptual framework that builds on three core principles. First, and central to the other two, is the principle that reminds us to "start where the people are." Articulated by health education leader Dorothy Nyswander (1956) nearly fifty years ago, starting where the people are is critical not only for demonstrating to communities our faith in them but also in ensuring that the issues we jointly address are the ones that really matter. As sociologist John McKinlay is fond of saying, professionals frequently suffer from an unfortunate malady known as "terminal hardening of the categories." We get the kinds of answers we are comfortable dealing with because we ask the kinds of questions that will give us those answers. In community health research, for example, residents may be told that HIV/AIDS or heart disease is a major health problem in their community and asked their opinions about various preventive health approaches. Although this may yield some valuable information, it may miss the fact that different issues, such as drugs, violence, or unemployment, may be of far greater concern to the community. Starting where the people are would have us shelve more traditional approaches, in which the researcher enters the community with his or her research topic and methods predetermined. Instead, and consistent with the principles of CBPR, it would have us foster a dialogical process though which the community's felt concerns

heavily shape and determine the topic chosen, how it is explored, and to what ends (Hall, 1992).

As suggested in Chapter Four, starting where the people are also means listening for and honoring what James Scott (1990) has called the "hidden transcripts," or private discourse of an oppressed community. The hidden transcripts may include stories, jokes, dreams, and fantasies and the kind of "plain talk" that cannot safely be expressed within earshot of the dominant class. Although much of the content of hidden transcripts is, by definition, not for public consumption by researchers and others outside the group, methodic listening and a willingness to take seriously the messages conveyed can be an important avenue for improving one's understanding of an oppressed group. Makani Themba (1999) points to rap music as "one of very few venues for expressing rage at the status quo as well as holding a candid discussion of social issues" (p. 22). Despite the commodification of and contradictions within some rap music, its ability to "chronicle the lived experience" of a sizable group of African American and other youth in America make it a powerful medium for CBPR participants committed to better understanding an oppressed group. Methodic listening to rap music and keen attention to other cultural expressions can form the basis for the dialogue that lies at the heart of CBPR.

Another dimension of "starting where the people are" involves a second core principle, which reminds us to recognize and begin with community strengths and assets, rather than problems. In their classic indictment of traditional "needs based" approaches to health and human welfare, Kretzmann and McKnight (1993) argue that well-meaning professionals and bureaucracies frequently hurt communities by characterizing them as "bundles of pathologies" or problems to be solved. Although such characterizations may be useful in attracting outside funding, they may do substantial damage by reinforcing a deficit mentality in which both community members and outsiders view the community in terms of its problems—needs and deficiencies to be "fixed" by outside experts (McKnight & Kretzmann, 1992).

The past two decades have witnessed a growing appreciation of the importance of a more balanced perspective, which begins by helping communities identify and build on their strengths. Community asset identification is used here as a broad concept to capture a variety of different processes through which communities themselves, often with the assistance of outside professionals, engage in the collection of such information. As Sharpe, Greany, Lee, and Royce (2000) have argued, "An assets orientation does not imply ignoring needs and problems or throwing out rational, strategic planning." But "by involving community members in visual, intuitive, and nonlinear processes of self-assessment and discovery, assets-oriented approaches invite more creativity in assessment and planning than collection and perusal of statistical data alone can engender" (p. 206).

The third and final principle embedded in community-driven approaches to asset identification and issue selection involves the heavy accent placed in CBPR on authentic dialogue. As discussed in Chapter Two, dialogue as described by Paulo Freire (1970, 1973) helps people "look at the 'whys' of their lives, inviting them to critically examine the sources and implications of their own knowledge" (Sohng, 1996, p. 86). In so doing, it facilitates co-learning by community members and researchers, and, as Sohng points out, avoids presupposing a frame of reference that is in fact the researcher's rather than the community's. Dialogical approaches thus lead to a far richer and deeper understanding of both community strengths and locally identified problems and issues than traditional researcher-as-interviewer-and-interrogator methods alone are likely to achieve.

In this discussion, we draw on each of these principles—starting where the people are, emphasizing and building on community strengths and assets, and using the power of dialogue—as they help inform community, rather than researcher-driven identification of community assets and selection of issues for community based participatory research.

IDENTIFYING COMMUNITY RESOURCES AND ISSUES: TOOLS AND APPROACHES

A host of tools and approaches that can be used to help communities identify their strengths and assets, as well as the problems or issues they wish to address, have been developed and refined over the past three decades. Although a full discussion of each of these is beyond the scope of this chapter, we attempt to provide an overview of several of the most promising approaches, as well as resources for finding more detailed information on each.

Walking and Windshield Tours

Crucial to identifying both community assets and potential issues or problems is being able to see one's community "through fresh eyes." One effective way of beginning this process is by walking, wheeling, or driving slowly through the community on weekends and weekdays, at different times of the day, observing and recording one's observations (Eng & Blanchard, 1990; Sharpe et al., 2000). In CBPR, both community residents and outside researchers may take part in this process, working individually or as teams and later sharing their impressions and observations. Although tape recorders, cameras, and even videotapes have been employed, windshield and walking tours typically involve simply handwritten notes or maps that highlight key observations. Such tours can provide valuable impressionistic data about things like the condition and types of local housing, the extent and nature of social interactions, the presence

of vacant lots and commercial and recreational facilities, and the general maintenance of buildings, yards, and common grounds (Eng, Briscoe, & Cunningham, 1990; Sharpe et al., 2000). Looking at the content of bulletins boards in community centers, libraries, houses of worship, and local stores or the public notices stapled to utility poles or fences can provide clues to local "hot" issues in the community.

Interviews with Formal and Informal Leaders and "Regular Folks"

As Sung Sil Lee Sohng (1996) has cautioned, the frequent reliance in community assessment on interviews with "key informants" necessarily limits the frame of reference of an interaction to that of the interviewer and further misses the co-learning that can come with more dialogical inquiry approaches. Yet there is clearly a place for thoughtful interviewing in community assessment, particularly if questions are formulated in ways that invite participants to share their pride and vision for their community, as well as their concerns and felt needs.

Interviews may be conducted with both formal leaders and informal ones—those "natural helpers" to whom people go for advice or help and who are often key behind-the-scenes players in helping neighborhoods function effectively. To identify such informal leaders, Israel (1985), Eng et al. (1990), Sharpe et al. (2000), and others have suggested that residents be asked questions like these:

- Whom do people in this neighborhood go to for help or advice?
- Whom do children go to?
- When this community has had a problem in the past, who has been involved in working to solve it?
- Who gets things done in the community?

Interviews with "regular folks," and particularly longtime residents are clearly key to identifying a core group of informal leaders who then should also be interviewed and ideally would be valuable participants in a CBPR project. Interviewers may also ask residents a variety of other questions, such as these:

- What do you like best about living in this neighborhood?
- What would you most like to see changed?
- What are some of the things other people are proud of in the community?
- Is this a good neighborhood in which to raise kids? (Why or why not?)
- When challenges or problems arose in the past, did the community come together to meet them? If so, can you give an example? How well did this collaboration work?

- Where in the community do kids go for fun or just to hang out?
- If youth get into a fight in this community, are adult residents likely to intervene?
- Do people in the neighborhood socialize with one another often? Do you socialize with others here?
- How would you characterize the relationships between members of different racial or ethnic groups in the neighborhood?

These and additional questions may be found in Duhl and Hancock (1988); Eng and Blanchard (1990); Hancock and Minkler (1997); Healthy Cities Network (http://www.healthycommunities.org); Israel (1985); and Sharpe et al. (2000). See also Appendix I.

The answers to questions like these can provide a wealth of initial data and stories about a community and may be compiled in narrative form or in the form of charts summarizing the key findings (Sharpe et al., 2000). As epidemiologist Chuck McKetney and his colleagues found in the Healthy Neighborhoods Project in Contra Costa County, California, however, the richest answers—and the best understanding of those answers—came when the interviews were conducted by local residents and then analyzed with their help (Minkler, 2000).

The Modified Delphi Process

The Delphi survey is a method for getting an opinion from a large group without needing to meet, while allowing for feedback and interaction. Trevor Hancock used a modified version of this in Toronto in the early 1980s to identify key health issues in the community. In each of two health areas, a panel of approximately one hundred community leaders from all walks of life were identified. In the first round of the survey, they were asked to identify what they saw as the three to five most important issues perceived as a threat to the health of the community. The results of this open-ended survey were collated, resulting in a list of around eighty issues. In the second round, the participants were sent this list (arranged in alphabetical order) and asked to score each item on a scale of 1 to 10 in terms of the item's importance as a determinant of the health of the community. These results were then compiled to generate a list ranked in order of priority. This list was then sent to participants, who were given a chance to reconsider their previous scoring on the basis of the collective opinion. (This resulted in little or no change in the rank ordering.) It should be noted that the issues identified through this process were not strictly within the mandate of public health. Nonetheless, the public health system had to respond and did so, thus ensuring that the community's identified issues were taken seriously.

The advantage of this process is that it enabled a wide variety of individuals to participate in a way that was not too time-consuming, with both the list of issues and the rank ordering of those issues determined by the participants

themselves. Although it is true that the participants were "community leaders," having approximately one hundred of them allowed for a wide range of perspectives. Given that this was the early 1980s, when a recession was under way, it is perhaps not surprising that the group identified unemployment, poverty, and similar issues as the major threats to the health of their community at that time. This had interesting implications for the health department, as discussed later.

Community Capacity Inventories

As we have suggested, an important alternative to the "community needs assessments" traditionally relied on in fields like public health and social welfare are capacity-focused efforts, which form a critical part of CBPR. The simplest such approaches often involve creating a capacity inventory, typically by developing a written list of the skills and talents of individual community members as well as the associations and other resources of the neighborhood as a whole. Although a simple survey can be used to help create this list, the information gleaned from windshield and walking tours, interviews, and other assessment methods described in this chapter can be used as well. Similarly, community newspapers or directories may contain references to dozens of individual and neighborhood-level resources while also themselves constituting important community assets. For a detailed guide to undertaking a comprehensive community capacity inventory, see Kretzmann and McKnight's *Building Communities from the Inside Out* (1993).

As McKnight and Kretzmann (1992) have pointed out, conducting a capacity inventory can be an important way of drawing attention to the gifts of "labeled" or stigmatized people as well as members of such often forgotten groups as elders and children. The earlier mentioned Healthy Neighborhoods project provided an excellent case in point. Project facilitators taped to the wall of a community center large pieces of butcher paper on which they listed headings such as "child care provision," "artistic abilities," "cooking for large groups" (as at wedding or funeral gatherings), and "non-English-speaking ability." Residents who previously had seen themselves as lacking any talents and special skills soon were signing their names under several skill categories (El-Askari et al., 1998; Minkler, 2000). Of particular importance in the aftermath of several anti-immigrant proposals and initiatives on the state level, moreover, was turning "speaking a language other than English" from a liability into a strength through the capacity inventory process.

Community Asset Maps

Closely related to community capacity inventories is the process through which community members themselves "map" local resources, abilities, and other building blocks for community growth and change (McKnight &

Kretzmann, 1992). A community asset map represents a means of laying out in a visual format the physical assets of a community—library, playgrounds, schools, parks, houses of worship—that may constitute important physical and social support structures for achieving community goals. Asset maps are often first drawn by individuals or teams who walk or ride through their neighborhood and indicate the assets they observe on their own hand-drawn maps. Using push pins on a large street map or land use map or through a collectively drawn asset map, they then share their individual perceptions and develop a map that represents the collective views of the group about community strengths or building blocks.

Although asset mapping is sometimes conducted by outsiders with minimal contact with residents, it becomes a potent tool in CBPR when community members play an active role in the process. Sharpe and her colleagues (2000) thus describe how the visual mapping of a South Carolina neighborhood by outsiders at first suggested that a local church was an important community meeting place. Through dialogue with residents, however, it became apparent that nearly all of the church's members lived outside the neighborhood, leaving local residents with little sense of identification with the institution. Asset mapping efforts that are driven by local residents are better able to accurately map community-perceived strengths and resources and can be a potent tool in CBPR.

Risk Mapping

The technique known as risk mapping was first developed by workers in an auto plant in Italy in the 1960s. Using a blueprint of the factory's production line and drawing on it circles of varying sizes and colors to indicate different workplace hazards, the workers then had their findings verified by a group of scientists (Labor Occupational Safety and Health Program, 1996). The risk mapping method was adapted and used by Mexico City health and safety activists in the 1970s and by the 1980s had achieved popularity in the United States as well. Health departments, university based occupational health centers, community based organizations concerned with environmental health issues, and unions are among the entities that have effectively used this approach (see Appendix G; Labor Occupational Safety and Health Program, 1996), which is now widely employed in the field of occupational health in the United States.

Risk mapping need not involve a shared work setting to be an effective tool in CBPR. Residents of a housing complex (such as an apartment building or a single-room-occupancy hotel) or pupils in a school can focus on shared spaces such as multipurpose rooms, hallways, and elevators to collectively identify hazards to which they are exposed. Typically under the guidance of a trained leader, community members sharing such a space are given a large piece of butcher paper and asked to draw a floor plan of the site, indicating boundaries, doorways, windows, and other key features. Colored markers then are used to

identify different types of hazards (physical, chemical, and so on) as described in Appendix G. Community members then discuss the various risks identified on their map, decide on those they most wish to address, and develop plans for further studying and taking action to address the chief hazards of concern to the group. Whether with workers, apartment dwellers, or others who share a geographic space, however, risk mapping can be a potent method for issue selection (see Appendix G).

A variant of the risk map is the community safety audit conducted by groups of women who examine potential threats to safety in their neighborhood by walking through it in a group at night, identifying poorly lit areas and other safety hazards (Wekerle & Whitzman, 1995). The problem areas thus identified can then be used as a basis for study and action to bring about change.

Community Dialogues or Guided Discussions

Engaging community members in dialogues or guided discussions about their communities has become an increasingly popular means of community assessment and issue selection. Within this broad category of approaches, focus groups are among the most popular, typically involving six to twelve diverse community members under the direction of a trained moderator. In a confidential and nonthreatening discussion, members address a series of questions about their communities, which are designed to elicit their beliefs about the strengths of their neighborhoods and the changes they'd like to see. Whether tape-recorded and transcribed or summarized through detailed handwritten notes, the output of focus groups can provide a wealth of information for thematic analysis and use in subsequent community-driven asset assessment and issue selection (Krueger & Casey, 2000).

Nominal group process (Delbecq, Van de Ven, & Gustafson, 1975) is a second small group method with considerable appeal for community assessment and issue selection. A structured process designed to foster creativity, encourage conflicting opinions, and prevent domination by a few vocal individuals, nominal group process is especially helpful in encouraging the participation of marginal group members (Hancock & Minkler, 1997; Siegel, Attkisson, & Cohn, 1977).

The Healthy Communities "community dialogues" (http://www.healthy-communities. org) represent a method that can involve either small groups or literally hundreds of individuals in diverse settings in a process of discussing their hopes and dreams for their communities and the issues about which they are concerned. Sample dialogue questions include the following:

- What do you believe are the two or three most important characteristics of a healthy community?
- What makes you most proud of our community?

- What are some specific examples of people or groups working together to improve the health and quality of life of our community?
- What do you believe is keeping our community from doing what needs to be done to improve health and quality of life?
- What would excite you enough to become involved (or more involved) in improving our community?

(See Appendix I for a full listing of the Healthy Communities dialogue questions and prompts or subquestions intended to deepen the dialogue in each of these issue areas.)

Finally, community dialogues also can be facilitated through town hall meetings and neighborhood forums. In Pasadena, California, some 150 residents participated in a daylong forum in which they decided on ten areas of concern, including housing, local employment, and alcohol and drugs. They then worked together in small groups to determine the "critical issues" in each of these ten areas for which indicators could be developed (Lasker, Abramson, & Freedman, 1998) as a prelude to community action for change.

Voting with Your Feet

An interesting and simple way to assist a group in identifying its priorities involves having members list their priorities and then asking people to move into groups for the priorities that have been identified. Since people cannot be in more than one place at a time, the level of commitment to the priority issues becomes apparent very quickly. An issue that is deemed very important (such as poverty) may in fact fail to attract any people to a work group forming to deal with it, perhaps because the issue is too big and people feel helpless in the face of it. Conversely, if most of the people in the room were to move into one particular group, this would indicate that a lot of time and energy should be committed to that issue, and in fact those people could form the core of a work group. (The fact that an issue receives no support from the participants on that day does not mean it is not an important issue but rather that the people in the room that day are not the right ones to deal with it.)

Developing Community Indicators

In recent years, much attention has been focused on the development and use of community health indicators (CHIs) that characterize a neighborhood or community as a whole, rather than simply the individuals or subgroups of which it is comprised (Cheadle, Wagner, Koepsell, Kristal, & Patrick, 1992; Hancock, Labonté, & Edwards, 1999). As Patrick and Wickizer (1995) suggest, such indicators take several forms and may be thought of as "a community analogue to health-risk appraisal for individuals" (p. 72). The number, type, and visibility of No Smoking signs in workplaces, the proportion of space in grocery stores

devoted to low-fat foods (Patrick & Wickizer, 1995), and the proportion of a community's children under age two with up-to-date immunizations are all examples of potent community health indicators.

Although such indicators are often created and employed by outside professionals, the very process of developing CHIs can be an important part of CBPR. Constituting as they do a limited set of quantitative and qualitative measures that reflect the current health status of the complex system that a community represents, CHIs can also suggest how the community's health status, broadly defined, is changing over time (Bauer, 1997). Ideally, as Hancock and his colleagues (1999) have pointed out, good community indicators should reflect six key determinants of health: environmental quality, economic activity, social cohesion and "civicness," equity (including power), sustainability, and livability. They should further capture four process dimensions—education, participation, empowerment and civil rights, and government performance—as well as the outcome of health status. Finally, Hancock et al. suggest that to be relevant to both policymakers and the general public, community indicators should have several key qualities:

- Face validity—they make sense to people
- Theoretical and empirical validity—they measure an important health determinant or dimension
- Social value—they measure things people care about
- Valency—they are powerful and carry social and political punch

Based on earlier work by Norris and Hancock, these investigators further propose the development of a CD-ROM based indicator selection tutorial that communities could use to choose indicators while learning about what indicators are and how to use them. Such a tutorial could be linked to web based data sets that would enable users to develop indicator reports.

As Georg Bauer has noted, "Because community health indicators draw attention to selected aspects of community health, they are crucial in setting the action agenda for our communities" (1997, p. 4). Consistent with this philosophy, an ambitious effort was undertaken in the late 1990s to develop community health indicators on the neighborhood level for and with the Fruitvale and San Antonio areas of Oakland, California, as a prototype for use in other neighborhoods. Coordinated by Bauer, a doctoral student at the School of Public Health, University of California, Berkeley, who was also a member of Oakland's Community Health Academy, the project was conducted through a partnership involving residents of the Fruitvale and San Antonio neighborhoods in Oakland; the Alameda County Department of Public Health; and the University of California, Berkeley, School of Public Health (see Appendix F). The Community Health Academy, a community based organization that grew out of the

W. K. Kellogg Foundation–funded Oakland Community Based Public Health Initiative (OCBPHI), was integral to the development and implementation of the community indicators project. Carrying forward the OCBPHI's original mission of moving away from "the domination and control of the health system by professionals through greater community involvement in local networks, cooperative planning, and collaborative partnerships" (Oakland Community Based Public Health Initiative, 1996), the Academy placed a heavy accent on local community development, capacity building, and advocacy for policy-level changes that can improve community health (see Appendix A).

The Fruitvale–San Antonio community health indicators project was committed to the notion of information as a vehicle for both change and community empowerment (Hancock & Minkler, 1997). As such, the small working group that met monthly to develop an initial list of indicators was guided by theoretical frameworks from community organizing, ecological perspectives on community health and sustainability, and the accent of the "new public health" on community partnerships, participation, and empowerment. Broad indicator categories included the following:

- Community capacity building and empowerment
- Community relations
- Community attraction (satisfaction with neighborhood, intention to stay, and so on)
- Cultural affirmation
- Youth development
- Community health and safety
- Physical environment
- Ecological sustainability
- Population health

For each of the issues identified in the working group meetings, local residents were asked about both their level of concern and their level of interest in taking action (Bauer, 1997). An area such as street violence (under "community health and safety"), to which almost three quarters of residents assigned "high importance" and over half reported "high interest in action," helped point the way for subsequent issue selection and community mobilization.

Visioning Processes

Community dialogues and the creation of healthy community indicators are often part of a larger visioning process through which a group of community members "collectively define a shared dream of what their community can become" (Sharpe et al., 2000, p. 209). Varying in length and format from a

daylong retreat to a yearlong process with multiple phases, visioning typically involves both small group work and large group convenings under the leadership of trained facilitators (see Appendix I).

The vision workshop process has been extensively used in healthy community projects. Groups as large as one hundred or more participants are taken through a process of guided imagery in which they see their community at some point in the future when it is as healthy as it could be. Then in small groups of six to eight, they are asked to draw a shared group picture of what they saw in their mind's eye. These pictures are then shared with the group as a whole, and common themes can be identified that are evident in most of the pictures. These common themes can then be the basis for issue development, since they reflect the most important factors that the participants recognize as being fundamental to the health of their community (Hancock, 1993).

In Clark County Community Voices 2010, in Vancouver, Washington, teen mothers, members of a Russian church group, and participants in a local senior organization were among a wide variety of community members who took part in a yearlong visioning process. Through focus groups, they addressed such questions as "What do you most like about your community?" "What are your hopes for your community's children twenty years from now?" and "Where would you put your energy to make the community a better place?" (Lasker et al., 1998).

As in the other community dialogue approaches described in this chapter, the processes involved in this activity can constitute a critical phase of CBPR, while the findings concerning community perceived strengths and issues in need of redress can form an important basis for subsequent research and praxis.

Creative Arts

Growing appreciation of the role that a variety of creative arts can play in helping communities identify their strengths and assets, as well as their shared problems and concerns (McDonald, Antuñez, & Gottemoeller, 1998), is grounded in part in the philosophy and methods of Paulo Freire. As he asked rhetorically, "How is it possible for us to work in a community without feeling the spirit of the culture that has been there for many years, without trying to understand the soul of the culture?" (Horton & Freire, 1990, p. 131).

A variety of techniques have been used to capture visual and oral expressions of the history, sources of pride, and shared concerns of a people. Key among these are community murals, vision workshop drawings, poetry and arts workshops, community plays about the history and present issues faced by the community, and videotapes capturing a wealth of perspectives on community life. As Marian McDonald and colleagues (1998) observed, "While art and literature are often solitary activities in the creation stage, the act of sharing art and literature is profoundly social and collective. By creating common reference

points through culture, communities begin to break down isolation, share their common experience, and build collective vision" (p. 273).

Illustrating this message, the photovoice process described in Chapter Nine provides a powerful means of helping community members document, through their own photographs, community assets and problems that in turn form the basis of dialogue, collective analysis, and action for social change. The process has been successfully used by such diverse groups as rural women in China (Wang & Burris, 1994), residents of low-income multicultural neighborhoods (Spears, 1999), homeless people (Wang, Cash, & Powers, 2000), and people with active tuberculosis (Butler & Xet-Mull, 2001) and has demonstrated considerable promise with each of these diverse populations (see Chapter Nine).

FROM ASSET AND PROBLEM IDENTIFICATION TO ISSUE SELECTION IN CBPR

The approaches we have described can provide a wealth of stories and data by and about a community and its resources, strengths, perceived problems or needs, and dreams for the future. The outside researcher or professional can often play a valuable role in helping community members learn about and use one or more of these methods and then critically reflect on what they have learned about their community as a basis for next steps in the CBPR process.

Because the methods described in this chapter are likely to reveal a wide range of problems of concern to the community, however, a critical step in CBPR involves helping community members "turn problems into issues" or identify those concerns they feel deeply enough about to systematically study and take action. In this process, the outsider can play a valuable role in asking the kinds of questions that can help community members decide on a specific issue or concern that can in turn form the basis of collective study and action for social change.

Community organizers provide a variety of guidelines and criteria for issue selection that can be adapted in CBPR. Borrowing from organizer Lee Staples (1997, p. 177), for example, and using *community* rather than *community organization* as the frame of reference, residents engaged in CBPR may evaluate the pros and cons of an issue they are considering by dialoguing about the following questions:

- Is the issue consistent with the long-range goals or agenda of the community (as identified, for example, through a visioning process)?
- Will the issue be unifying or divisive?
- Will the issue contribute to community capacity building?

- Will the process of CBPR on this issue provide a good educational experience for leaders and community members, developing their consciousness, independence, and skills?
- Will the community receive credit for a victory?
- Will working on this issue result in new partnerships or alliances?
- Will CBPR on this issue result in concrete action for change and produce new issues for subsequent CBPR efforts?
- Will CBPR on this issue lead to an improved health or social outcome for the community?
- Is the issue important enough to people that they are willing to work on it?

As suggested by this list, a good issue for a CBPR effort will be consistent with the community's overall vision of itself as a healthy community and help it move toward that vision. Similarly, and while recognizing that communities are not homogeneous in their goals and values (Labonté, 1997), a good issue will be selected through a democratic process that helps avoid the kind of divisiveness that can weaken rather than strengthen the community (Staples, 1997). A good issue will not only appeal to a broad range of community members but also lend itself to the provision of multiple opportunities for participation in the CBPR process. Similarly, a good issue will attract new leaders and provide both leaders and members of the community with opportunities for developing a variety of skills and abilities that contribute to capacity building on the individual, organization, and community levels. Ideally as well, the issue chosen will attract external funding and other outside supports that can further help expand the community's resource base (Staples, 1997). In a related way, an issue may attract other potential community or institutional partners whose participation may further enhance aspects of the CBPR process while contributing to local capacity building.

Like community organizing, CBPR for health is ultimately concerned with bringing about social change that will promote the health and well-being of the community. The process of issue selection should therefore also involve dialogue about whether and how CBPR on the issue under consideration could ultimately help bring about conditions in which the community can be a better and healthier place in which to live. An issue that excites people but has little or no prospect of leading to actions that could ultimately help improve community health would not meet this important criterion as a "good issue" for CBPR.

In sum, many factors need to be considered by communities as they decide on the issue or issues that will drive a CBPR effort. By fostering a dialogue using the types of questions and guiding considerations discussed here, the outside researcher or professional can play an important role in helping community members with this critical stage in the CBPR process.

WHEN PREEXISTING (EXTERNAL) GOALS CONSTRAIN ISSUE SELECTION: A FINAL NOTE

This chapter has been written from the perspective that communities can and should have a major role in determining the problem or issue to be studied and addressed through a CBPR process. Yet as earlier chapters have made clear, achieving true community-driven issue selection is often difficult in practice. Public health researchers thus frequently approach a community concerned about its high rates of HIV/AIDS or substance abuse and wishing to collaborate in studying the problem and developing a community based intervention. Similarly, funding mandates may sharply circumscribe the areas within which issue selection may take place.

The federal government's initiative to eliminate disparities in health represents a good case in point. When the Centers for Disease Control and Prevention (CDC) made substantial funds available for eliminating health disparities, it earmarked six "areas of focus" within which such efforts must take place: cancer screening and management, cardiovascular disease, child and adult immunizations, diabetes, HIV/AIDS, and infant mortality (U.S. Department of Health and Human Services, 1998). All six of these represent areas where serious disparities in both health access and health outcomes continue to exist by race and ethnicity. Yet for communities upset over drugs in their children's playgrounds, violence, or high unemployment rates, none of these six may represent an issue of central concern.

The federal campaign to eliminate health disparities represents a classic dilemma for communities and the outside professionals with whom they collaborate in CBPR. On the one hand, the availability of funds to conduct CBPR can be a boon to communities, providing resources and stimulating partnerships that can help them tackle major health problems. On the other hand, however, limiting funding to the six specified areas may violate the basic principle of community-driven issue selection.

For communities and their professional allies engaged in CBPR within the constraints imposed by initiatives like the federal effort to eliminate health disparities, some useful lessons may be learned from such related efforts as the National Healthy Start Program (NHSP) to reduce infant mortality. When the NHSP commenced in 1991, the U.S. ranked twenty-second in the world in infant mortality, and the black infant death rate was more than twice that of the white rate (Public Health Service, 1996). The program's goal was to reduce infant mortality by half over a five-year period in fifteen demonstration sites, plus an additional eighty sites added by the late 1990s. Although specifically targeting infant mortality, however, program guidelines also emphasized the need for "substantive and informed" community participation through consortia and other means designed to foster community-driven approaches at

every stage of the process (Health Resources and Services Administration, 1991, p. 4). As a consequence, community consortia often engaged participants in studying and addressing issues *they* identified. In Cleveland, for example, residents successfully took on a local hospital's use of an incinerator that was creating an environmental hazard, while in Chicago, participants, through their consortia, studied the new welfare reform time limits and work requirements and worked to get waivers in place for mothers with special needs children (Minkler, Thompson, Bell, & Rose, 2001; Thompson et al., 2000).

Taking a cue from such examples, CBPR projects that begin in response to problem-specific community based health initiatives can, with creativity and attention to the interconnections between many health and social issues, often "broaden the net" so that issues of primary concern to the community become a driving force for the collaborative research and action undertaken.

This chapter has provided a broad overview of the core principles underlying community-driven asset identification and issue selection and their relevance for CBPR. We also have described and illustrated by example a number of different tools and approaches that may be useful in helping communities recognize and build on their strengths and collectively identify issues about which they feel strongly enough to engage in systematic inquiry and action. Our overview of tools and methods has intentionally omitted an important and growing category of approaches, those that involve the use of computer technology in assessing community resources and potential issues for CBPR. It is to these increasingly potent tools for assessment and issue selection that we turn in the next chapter.

References

Bauer, G. F. (1997). *Community health indicators on the neighborhood level: A prototype for the Fruitvale/San Antonio area in Oakland.* Oakland, CA: Oakland Community Based Public Health Initiative/Community Health Academy.

Butler, L. M., & Xet-Mull, A. M. (2001, November 8). *Through our eyes: Understanding the experience of tuberculosis with photovoice.* Paper presented at the Human Rights Summer Fellowship Conference, University of California, Berkeley.

Cheadle, A., Wagner, E. A., Koepsell, T. D., Kristal, A., and Patrick, D. (1992). Environmental indicators: A tool for evaluating community-based health promotion programs. *American Journal of Preventive Medicine, 8,* 345–350.

Delbecq, A., Van de Ven, A. H., & Gustafson, D. H. (1975). *Group techniques for program planning: A guide to nominal group and Delphi processes.* Glenview, IL: Scott, Foresman.

Duhl, L., & Hancock, T. (1988). *A guide to assessing healthy cities.* Copenhagen, Denmark: FADL.

El-Askari, G., Freestone, J., Irizarry, C., Kraut, K. L., Mashiyama, S. T., Morgan, M. A., & Walton, S. (1998). The Healthy Neighborhoods Project: A local health department's role in catalyzing community development. *Health Education and Behavior, 25,* 146–159.

Eng, E., & Blanchard, L. (1990). Action-oriented community diagnosis: A health education tool. *International Journal of Community Health Education, 11*(2), 93–110.

Eng, E., Briscoe, J., & Cunningham, A. (1990). The effect of participation in water projects on immunization. *Social Science and Medicine, 30,* 1349–1358.

Freire, P. (1970). *Pedagogy of the oppressed.* New York: Seabury Press.

Freire, P. (1973). *Education for critical consciousness.* New York: Continuum.

Hall, B. L. (1992). From margins to center: The development and purpose of participatory action research. *American Sociologist, 23,* 15–28.

Hancock, T. (1993). Seeing the vision, defining your role" *Healthcare Forum Journal, 36*(3), 30–36.

Hancock, T., Labonté, R., & Edwards, R. (1999). Indicators that count: Measuring population health at the community level. *Canadian Journal of Public Health, 90*(Suppl. 1), 22–26.

Hancock, T., & Minkler, M. (1997). Community health assessment or healthy community assessment: Whose community? Whose health? Whose assessment? In M. Minkler (Ed.), *Community organizing and community building for health* (pp. 139–156). New Brunswick, NJ: Rutgers University Press.

Health Resources and Services Administration. (1991). *Guidance for the Healthy Start program.* Washington, DC: Author.

Horton, M., & Freire, P. (1990). *We make the road by walking: Conversations on education and social change* (B. Bell, J. Gaventa, & J. Peters, Eds.). Philadelphia: Temple University Press.

Israel, B. A. (1985). Social networks and social support: Implications for natural helper and community-level interventions. *Health Education Quarterly, 12,* 66–80.

Kretzmann, J. P., & McKnight, J. L. (1993). *Building communities from the inside out: A path toward finding and mobilizing a community's assets.* Chicago: ACTA.

Krueger, R. A., & Casey, M. A. (2000). *Focus groups: A practical guide for applied research* (3rd ed.). Thousand Oaks, CA: Sage.

Labonté, R. (1997). Community, community development, and forming of authentic partnerships: Some critical reflections. In M. Minkler (Ed.), *Community organizing and community building for health* (pp. 88–102). New Brunswick, NJ: Rutgers University Press.

Labor Occupational Safety and Health Program. (1996). *A group method for improving risk mapping: Workplace health and safety.* Los Angeles: University of California, Labor Occupational Safety and Health Program.

Lasker, R. D., Abramson, D. M., & Freedman, G. R. (1998). *Pocket guide to cases of medicine and public health collaboration.* New York: Center for the Advancement of Collaborative Strategies in Health/New York Academy of Medicine.

McDonald, M., Antuñez, G., & Gottemoeller, M. (1998). Using the arts and literature in health education. *International Quarterly of Community Health Education, 18,* 269–282.

McKnight, J. L., & Kretzmann, J. P. (1992). *Mapping community capacity.* Evanston, IL: Center for Urban Affairs and Policy Research, Northwestern University.

Minkler, M. (2000). Participatory action research and healthy communities. *Public Health Reports, 115,* 191–197.

Minkler, M., Thompson, M., Bell, J., & Rose, K. (2001). Contributions of community involvement to organizational-level empowerment: The federal Healthy Start experience. *Health Education and Behavior, 28,* 783–807.

Nyswander, D. (1956). Education for health: Some principles and their application. *Health Education Monographs, 14,* 56–70.

Oakland Community Based Public Health Initiative (OCBPHI). (1996). *Annual report to the W. K. Kellogg Foundation.* Oakland, CA: Community Health Academy.

Patrick, D. L., & Wickizer, T. M. (1995). Community and health. In B. C. Amick, S. Levine, A. R. Tarlov, & D. C. Walsh (Eds.), *Society and health* (pp. 46–92). New York: Oxford University Press.

Public Health Service. (1996). *Health: United States, 1995.* DHHS Publication No. (PHS)96-1232. Hyattsville, MD: U.S. Department of Health and Human Services.

Scott, J. (1990). *Domination and the arts of resistance: Hidden transcripts.* New Haven, CT: Yale University Press.

Sharpe, P. A., Greany, M. L., Lee, P. R., & Royce, S. W. (2000). Assets-oriented community assessment. *Public Health Reports, 113,* 205–211.

Siegel, L. M., Attkisson, C. C., & Cohn, I. H. (1977). Mental health needs assessment: Strategies and techniques. In W. A. Hargreaves & C. C. Attkisson (Eds.), *Resource materials for community mental health program evaluation* (2nd ed., pp. 46–65). Washington, DC: U.S. Government Printing Office.

Sohng, S.S.L. (1996). Participatory research and community organizing. *Journal of Sociology and Social Welfare, 23*(4), 77–97.

Spears, L. (1999, April 11). Picturing concerns: The idea is to take the messages to policy makers and to produce change. *Contra Costa Times,* pp. A27, A32.

Staples, L. (1997). Selecting and cutting the issue. In M. Minkler (Ed.), *Community organizing and community building for health* (pp. 175–194). New Brunswick, NJ: Rutgers University Press.

Themba, M. N. (1999). *Making policy, making change: How communities are taking law into their own hands.* San Francisco: Jossey-Bass.

Thompson, M., Minkler, M., Allen, Z., Bell, J. D., Bell, J. K., Blackwell, A. G., et al. (2000). *Community involvement in the federal Healthy Start program.* Oakland, CA: PolicyLink.

U.S. Department of Health and Human Services. (1998). *Call to action: Eliminating racial and ethnic disparities in health.* Washington, DC: Author/Grantmakers in Health.

Wang, C. C., & Burris, M. A. (1994). Empowerment through photo novella: Portraits of participation. *Health Education Quarterly, 21,* 171–186.

Wang, C. C., Cash, J. L., & Powers, L. S. (2000). Who knows the streets as well as the homeless? Promoting personal and community action through photovoice. *Health Promotion Practice, 1,* 81–89.

Wekerle, G., & Whitzman, C. (1995). *Safe cities: Guidelines for planning, design, and management.* New York: Van Nostrand Reinhold.

Wing, S., Grant, G., Green, M., & Stewart, C. (1996). Community based environmental justice: Southeast Halifax environmental awakening. *Environment and Urbanization, 8,* 129–140.